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Case Study

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SURGICAL STEPS FOR HYSTERECTOMY IN A LARGE CERVICAL FIBROID: A RARE CASE REPORT

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ABSTRACT

Although leiomyomas are the most common pelvic tumours presenting in the reproductive age group, cervical fibroids are rare accounting for 2% of all uterine fibroids. We report a case of 48 year old lady presenting with heavy menstrual bleeding and severe anaemia due to a firm, non-tender mass of 36 weeks size globular uterus with restricted mobility. Laparotomy showed a large mass arising from the anterior lip of cervix, with a small uterus pushed superiorly. Enucleation followed by total abdominal hysterectomy was done. Large cervical fibroids present with surgical difficulties. Careful dissection by expert hands is needed in the management of such cases.

KEYWORDS: Enucleation, Laparotomy, Large cervical fibroid, internal iliac ligation.

INTRODUCTION

The vast majority of women with fibroids go through life without knowing they harbour fibroids in their womb.

The incidence of leiomyoma in the reproductive period is 20%. Only 2% of these arise from the cervix.[1] Cervical fibroids are classified depending on their location as anterior, posterior, lateral and central. They can be further classified as interstitial, subserosal and submucosal polypoid.[2] Large cervical fibroids generally present with pressure symptoms like retention of urine or constipation or sometimes as abdominal mass mimicking ovarian mass. Due to their close proximity, there is increased risk of bladder and bowel injuries along with risk of intraoperative bleeding. Laparotomy is the most common mode as these are difficult to handle and meticulous surgical dissection is important.

CASE REPORT

A 48-year-old parous woman presented to our emergency department with complaints of heavy menstrual bleeding with passage of clots, severe abdominal pain & dizziness. She had no urinary retention, urgency, constipation General and systemic examination was normal except for severe pallor. Abdominal examination revealed a large mass occupying entire abdomen from xiphi sternum upto pubic symphysis. It was firm to feel with smooth margins, restricted mobility and there was no abdominal tenderness. Lower margin could not be reached. On per speculum examination bleeding was seen. Per vaginum examination revealed a firm mass dilating the cervix to 10 cm (resembling fully dilated cervix of a labour patient). Bimanual examination showed a large solid mass with restricted mobility filling the pelvic cavity extending up to the umbilicus. Uterus could not be felt separate from the mass. Abdominal ultrasonography showed a large well defined fibroid occupying the abdomen. Mild bilateral hydroureteronephrosis & hydroureter was seen. Routine laboratory test results were normal, except the haemoglobin level, which was 4.5 g/dl. After anaemia correction with PCV transfusion, total abdominal hysterectomy and bilateral salpingo-oophorectomy was performed. The final diagnosis was a 30x 25x 20 cm, 3.5 kg cervical leiomyoma with lantern on dome appearance that occurred without secondary changes, degeneration, calcification or haemorrhage.

Surgical principles

Care was taken to isolate the ureters prior to enucleation followed by total abdominal hysterectomy and bilateral salpingo-oophorectomy.

Detail application of pelvic anatomy, fine dissection, taking every effort to decrease intra-operative bleeding.

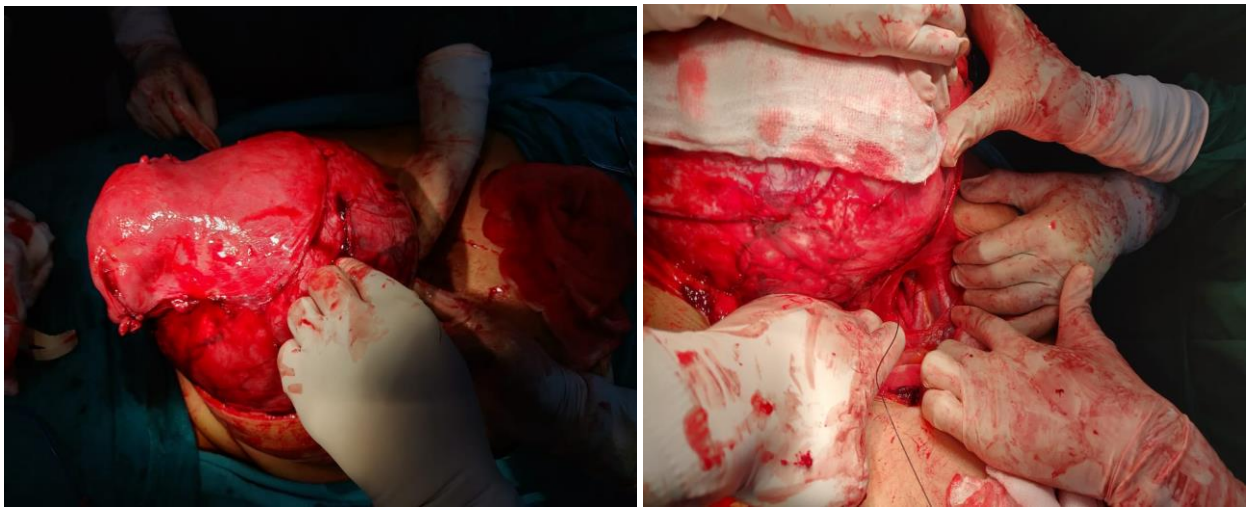
Surgical steps

Vertical midline abdominal incision taken from 4 cm above umbilicus upto pubic symphysis. Abdomen opened in layers. Evidence of 30 x 20 cm cervical fibroid. Round ligaments ligated & incised. UV fold of peritoneum opened & Bladder pushed down. Tubo-ovarian separated from mass & window created, ligated & cut. Infundibulopelvic ligaments not transected as

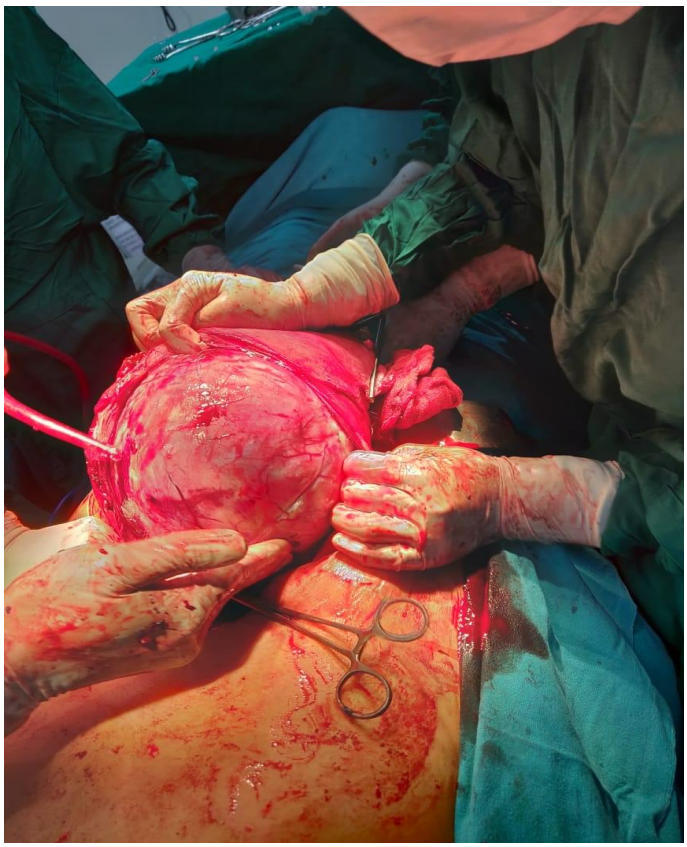
ureters not identified yet. Capsule of peritoneum cut posteriorly & pushed upto rectum. Care taken to remain gentle & not to injure big vessels on mass. After reaching below mass, huge fibroid delivered through incision. Uterus with cervical fibroid pulled caudally & with difficulty pelvis visualized. With lateral dissection ureters identified, internal iliac artery & ovarian vessels ligated. Shifting fibroid right/left, both ureters traced from common iliac upto uterine vessels & then to its bladder entry. Now safely uterine vessels clamped, cut & ligated above ureter. Now posteriorly incision on capsule taken, blunt dissection done with finger & huge myoma removed leaving behind large redundant capsule.

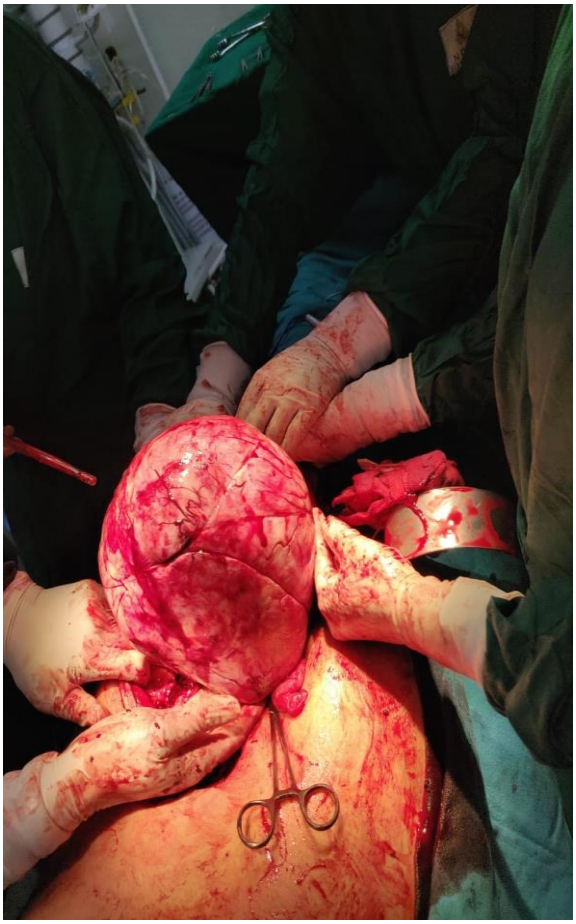
Again everything arranged in anatomical order, cervix totally effaced. Posterior vaginal wall caught in allis & opened to enter vagina. Now cervix traced & below it vagina cut. Care taken on lateral side to protect ureter and secure vaginal vessel bundle. Specimen removed, vagina closed. Estimated blood loss was 500ml.

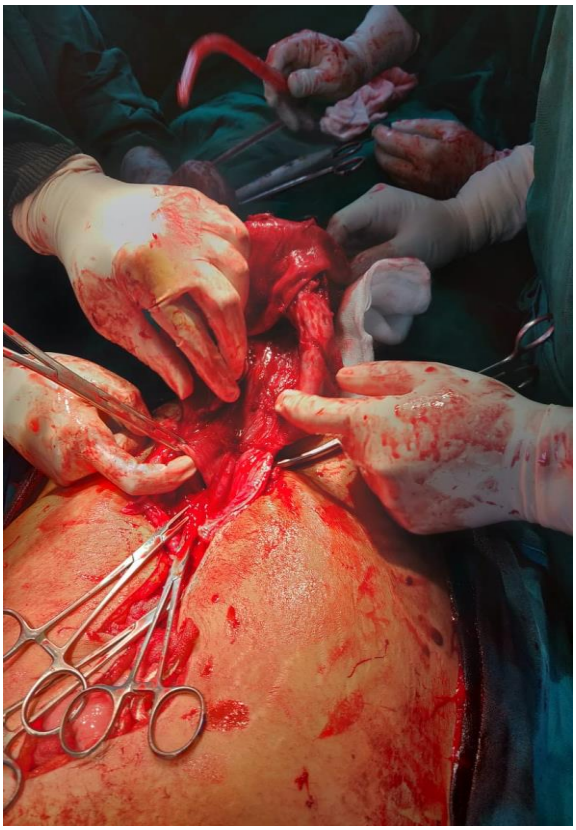
Post op period was uneventful. Patient was discharged on day 6 after correction of anemia. Histopathology showed leiomyoma.



Internal iliac artery ligation







DISCUSSION

There are very few cases of large cervical fibroids reported in literature. Excessive growths in cervical fibroids are rare. They generally present with symptoms of pressure effects however, in this case the patient was largely asymptomatic till she presented with heavy menstrual bleeding.

Unusual presentations of cervical fibroids are also seen. Sushmita sharma and coworkers reported a case of large cervical fibroid of 30*26*22 cms which presented as abdominal mass.[3] It was initially confused as an ovarian neoplasm as the fibroid had hyaline and cystic degeneration. Abdominal hysterectomy was the choice of surgery in this case. B Kavitha and coworkers reported a case of large central cervical fibroid with typical "Lantern on top of St. Paul" appearance.[4] Total abdominal hysterectomy was done along with ureteroureteric anastomosis, bilateral ureteric stenting and bladder repair.[3]

Samal SK et al, reported a case of large cervical fibroid 25x20x15 with mild hydroureteronephrosis.[5] Cervical fibroid was enucleated after hemisection. Hemisection of the uterus was done in the relatively avascular mid-line according to Rutherford Morrison's technique with a scalpel and the incision was carried downwards well in to the tumour so that the plane of its capsule is easily distinguished. Ureters were traced and found intact before proceeding with hysterectomy.

In this case, patient presented with heavy menstrual bleeding. Abdominal examination confirmed fibroid although site was not clearly made out. Bimanual examination hinted towards cervical fibroid. In lower uterine fibroids, peritoneal reflection is below the lower border of fibroids unlike cervical fibroids where the reflection is above and hence inaccessible.

CONCLUSION

Treatment of huge cervical fibroids is either by hysterectomy or myomectomy. Myomectomy can be tried in young patients. During surgery, due to proximity of ureters, careful enucleation followed by dissection should be done. During enucleation, limiting dissection to within the capsule is the key to preventing ureteric injury.

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